COMMUNITY MENTAL HEALTH: THE SEARCH FOR IDENTITY

Address to

Inaugural Plenary Session

World Mental Health Assembly

Regency Room, Shoreham Hotel, Washington, D. C.

Tuesday Morning, November 18, 1969

by

MIKE GORMAN, Washington, D. C.

Executive Secretary, International Committee Against Mental Illness
Executive Director, National Committee Against Mental Illness, U. S. A.
Member, National Mental Health Advisory Council, U. S. Public Health Service
Member, 1st U. S. Mental Health Delegation to U. S. S. R. (Sept., Oct., 1967)
Fellow, American Psychiatric Association (Hon.)
Fellow, Royal Society of Health, England

The timing of this plenary session on community mental health at so distinguished

an international gathering is most fortunate, since in various parts of the world there

is a rather considerable debate going on about the future of community psychiatry

generally, and of the community mental health center in particular. As a representative

of the United States on this panel, I am delighted that we have a _future_ to talk about --

up until very recently in this country, we could really only venture tangential references

to some limited experimentation in the heart of the community.

In the admittedly constricted perspective which six years of operation on a

national scale bestows upon us, we are beginning to comprehend the truly revolutionary

nature of what we have wrought in altering radically the profile of American psychiatry.

The distinguished Boston revolutionary and abolitionist, Wendell Phillips, noted more than a century ago that:

"Revolutions are not made; they come. A revolution is as natural a growth as an oak. It comes out of the past. Its foundations are laid far back. "

For almost two centuries here in America, the psychiatric landscape was grim and forbidding. The large mental hospitals -- secular cloisters of the mad -- grew to such outlandish size that as recently as the mid-1950's, a number of them were in the ten to fifteen thousand bed range.

The cumbrous custodial institution had its fair share of critics over a span of many years, but the voices of discontent became a loud chorus after World War II. During the Second World War, we in this country -- and those of you representing other countries around the globe -- were quite shocked at the number of young men whom we had to reject for the armed services because of psychiatric disabilities. On the other hand, the American public got its first glimpse of what non-institutional psychiatry could do in restoring men with psychological breakdowns to active duty.

There were other elements contributing to a revolt against the warehousing of the mentally ill in remote institutions. In certain parts of our land, newspapers began to probe into the inhumane level of custody in state hospitals. The internal criticism was accelerated by American professionals who travelled abroad and brought back reports of the beginnings of a new and exciting community-based psychiatry in Amsterdam, in Scotland, in England, and in the Scandanavian countries. Always eager

to rediscover history -- for the first time -- our scientific journals printed stories of the glories of the care and treatment of the mentally ill in the community going back to the 11th century in Gheel, Belgium.

It is difficult to delineate the exact ingredients which, when properly simmered over a stove, produce a revolution. But there is little doubt that many of our hospital superintendents, in the great tradition of Marie Antoinette, rattled their keys in defiance at those who were trying to smuggle a breath of the community beyond the feudal walls. Secondly, although our professional jurisdictions were beginning to deal antiseptically with the idea of community mental health, progress was slow. In the period 1945 to 1955 alone, 130,000 additional mental patients were jammed into the already over-crowded wards of our 300 state hospitals.

I am in full agreement with Dr. Arne Querido on the one common factor which has generated community mental health services in a number of countries:

"A certain urgency, a certain must, a certain pressure

requiring action. The theory comes much later."

The various rumblings of discontent finally coalesced into a concensus leading to the establishment of a Congressionally supported Joint Commission on Mental Illness and Health in 1955. Its final report, released six years later, sounded the death knell of the isolated cities of the mad. President John F. Kennedy endorsed the major recommendations of the Commission's report; in his historic 1963 mental health message to Congress, he called for a network of community mental health centers to replace eventually the backwater, insulated institutions of the past.

I auppose it is not surprising that neither the Joint Commission report nor President Kennedy's 1963 message were greeted with universal acclaim. Neither, for that matter, was our own Declaration of Independence in 1776. As the very perceptive French social critic, Maurice Maeterlinck, observed many years ago:

> "At every crossway on the road that leads to the
>
> future, each progressive spirit is opposed by a
>
> thousand men appointed to guard the past. "

In this troubled year of 1969, how are we faring with the centers program in relation to President Kennedy's goal of 2,000 centers by 1980? We made a strong beginning, but the fiscal limitations dictated by the war in Vietnam have hurt us badly over the past three years. There are approximately 200 centers open at the present time, and another 150 which have pulled together varying amounts of local, state and federal matching monies and will open in the next year or two. In the face of admonitions to the contrary, we still hold fast to the goal of 2,000 centers by 1980.

What are we trying to achieve in the community mental health center concept? Our goal is simple and clear: It was expressed quite well in a recent publication of the Group for Advancement of Psychiatry, a coterie of some of our nation's most progressive psychiatrists:

> "We are no longer content to banish the mentally ill
>
> to a world that we shun and deny. Instead, with all
>
> the unpleasantness, difficulties and trials that ac-
>
> company professional role changes, we seek ways to
>
> bring the mentally ill into the life of the community. "

Viewed in context, the community mental health center is part and parcel of

a healthy revolt against the impersonal colossi of our age -- big government, the vast

military-industrial complex, enormous universities which have become insensitive

diploma mills and social welfare institutions of all kinds whose bureaucratic procedures

violate and offend the dignity of the individual.

The better mental health centers -- many of them concentrated in the ghetto

areas of our large cities -- seek out the disturbed individual formerly lost in the chaos

and confusion of urban life. Mental health professionals join with specially trained

community residents and move into homes, schools, police stations, churches, and

on to the streets themselves. Mental health services are now as close to the people

as the store front clinic down the block or around the corner.

Many walk in off the street and through the open door. One such was a middle-

aged man who told the receptionist at a center in one of our largest cities:

"My son is 15. He is a smart boy but he is afraid

to go to school. He gets nervous. The same thing with

my missus; she is nervous, she aggravates him. The

whole house is upset. "

In a few days, the whole family was attending a two-hour family therapy

session jointly conducted by one of the center's psychiatrists and a social worker.

A number of these sessions followed, each costing the family the sum of one dollar.

These centers learn very quickly that a patient coming out of a severely

denuded environment cannot be helped significantly until the noxious milieu in which

the illness festers is tackled.   This has resulted in a number of our centers becoming

involved in housing committees and tenant councils which force slumlords to improve

living conditions; in efforts to improve the low level of medical services in an area,

with particular emphasis upon good pre-natal care leading to a reduction in the high

rate of premature babies born with brain damage and other sequelae of the ghetto; in

establishing remedial educational courses, many of them staffed by the older children

in the neighborhood and, yes, even encouraging these previously alienated people to

register and to vote so that they can truly participate in electing officials pledged to

improve conditions which presently generate so much mental illness and mental

disturbance.   As the director of one of these centers put it recently:

> "Mental illness is really a social problem.   It is not
>
> exclusively a psychological or a biological one.   We frankly
>
> have to help people change their communities if necessary."

Engaging the people who are the consumers, the supposed rason d'etre of the

center's activities, in its decision-making processes is not without its problems.   In

several recent instances, the newly liberated people revolted against the professional

overlords of the center and demanded a major say in the promulgation of policy and

personnel decisions.   It is too early in the history of community psychiatry here in

this country to hazard any definitive pronouncements as to the best possible mix of

professional stewardship and consumer involvement, but it is incumbent upon those who

now tell us they knew we were headed for trouble to remember that any sharp and

revolutionary break with heavily encrusted tradition involves a good deal of disturbance

and controversy.   Many of these hand-wringing critics embraced the idea of community

psychiatry within the safe confines of pallid essays in their jurisdictional journals; they now look askance at the physical implementation of the archetype. Most revolutions start off with lofty pronouncements; they threaten the existing order only when the cobblestones begin to fly and the barricades are stormed.

At this point in time, what are the pluses and minuses in drawing up a balance sheet of the performance and potential of the community mental health center movement?

On the positive side, I think even the most vociferous critics of the center program will agree that it has brought psychiatric care to hundreds of thousands of our citizens who were never reached before. Furthermore, it has added a fresh and attractive dimension to mental health services by vizualizing the patient in the totality of his fantastically diverse inter-relationships as a member of the family, of the world of work and of an alien society. There is a new thrust toward understanding, and helping the patient grapple with, the fierce external pressures which cascade in upon him. Until very recently in this country, therapists seemed to be treating endogenous, carefully isolated symptoms within a narrowly defined spectrum of "acceptable and manageable" maladies. In our public institutions, these symptoms served to define the very identity of the patient; he was quickly and conveniently labeled, put on the ward which handled that kind of disorder, and expected to act up or out in strict conformity with his prescribed diagnostic status. If he was affluent enough to afford private psychiatric care, he quietly slipped into a darkly furnished office and regurgitated symptoms from the approved lexicon upon cue from the omnipotent therapist.

The better centers in this country treat the patient as both enmeshed in, and a product of, a complex and stressful world. Their efforts are tailored toward supportive measures so that he may function, in however limited a way, in this society; they reach for positive strengths which can be capitalized upon to bring him into a degree of adaptation with his environment. For almost 200 years, we wrongfully stripped him of this individuality so that he could conform to the requirements of our massive, understaffed public mental hospitals. He shuffled in endless lines; he sat in rocking chairs; he had no individual clothing or belongings, and he ate from a tin plate in a grimy mess hall with several thousand robotized brethren.

This -- the affirmation of the dignity of the individual suffering from an illness -- is the most positive contribution of the community mental health center movement.

I could dwell at much greater length upon additional achievements of the center in the area of community psychiatry, but I think it would be much more helpful and illuminating to those of you representing other countries to discuss some of the nagging obstacles to the fulfillment of our dream.

There are centers in this country which are little more than the traditional closed-door psychiatric units in general hospitals. They have just changed the lettering on the entrance to the ward. There are other centers which are suffering from shortages of mental health manpower, although I am happy to note that these are definitely in the minority. We have engaged in this country, over the past 20 years, in a training effort in the field of mental health manpower which has no parallel in the annals of modern medicine. The younger products of this training pipeline are now gravitating in increasing numbers toward our Centers.

A major obstacle to the development of centers which truly guarantee continuity of care for the patient is the pluralistic nature of our democratic society. We have a plethora of health and welfare agencies of all kinds in our communities; most of them seem to have a proprietary interest in some defined segment of the patient. In order to lead the patient through this thicket of predatory agencies, we are developing a new breed of guides, variously known as expiditers, facilitators, indigenous workers, and so on. In visiting community mental health services in a number of countries in Western Europe and Russia, I got the distinct impression that continuity of care and constant evaluation of a patient was possible without a traffic cop to help the patient through a maze of conflicting jurisdictions.

We also suffer to some degree from our Puritanic heritage. It is fairly nice to be a top banana in America, but it is pretty ghastly to be a failure. Our rigidly moral view of aberrant behavior and eccentricity is at the root of our impatience with non-success -- we don't want to look at it, so we try to banish its victims. We have made considerable progress in ameliorating the harshness of moral banishment in recent years, but the alcoholic, the drug addict, the emotionally disturbed child and other troubled segments of our population have difficulty in some regions in achieving community acceptance.

Paradoxically, although we are a society which theoretically celebrates fierce competition and diversity, we can become amazingly inflexible in the design and location of social services. Possessed of an edifice complex, we frequently place all services in one gleaming building. We travel abroad and admire the natural setting of mental health components in factories, housing projects and in schools in Russia, England, and elsewhere, yet most of our centers today are located in our general hospital

system. We write ecstatically about the extent of home visiting to patients in Russia,

in England, and in the Netherlands, yet I hazard a guess that the few centers in our

country with a regular program of home visiting do not exceed in combined total

the 6,000 visits a year by the Municipal Health Service of Amsterdam.

The thorny question of the financing of community mental health services is

still very much of an issue in the United States. Although we support the mental health

centers under a loosely defined amalgam of federal, state and local contributions, we

are beginning to see that the impermanance of such finding severely circumscribes the

outreach of many centers, particularly those in less-favored economic areas. Further-

more, the fantastic number of private health insurance plans in this country -- many

with sharply varying levels of coverage for mental illness -- makes it impossible to

guarantee the centers a stable source of income. In Great Britain, for example, where

all people are covered under a national health insurance system, there is continuity of

care because the dragon of ability to pay is never invoked. It is the belief of many of

us that the community mental health center movement will achieve neither stability nor

its true potential until we devise a universal system of prepaid medical care.

Above and beyond this, we have acquired the usual band of carping critics who

have been snapping at our heels from the very day the Kennedy message went to Congress.

From many points of view, this is all to the good; if we weren't such a potent threat to

the Establishment, there wouldn't be that much yowling and caterwauling.

Of course, the analysts are after us. In recent years, we have been subjected to

articles on the internal and/or neurotic problems of mental health centers; discussions

of the transference phenomena between centers and the community, and a diagnosis from Olympus of the supposed major ills of the center, including "identity diffusion", "grandiose ideation", and "agency neurosis".

Our analytic friends even have the temerity to criticize the unrefined swarms of patients now being tended by the centers. Because of this unwashed influx, contends Dr. Benjamin Brody:

> "Patients are no longer patients in the usual psycho-
> therapeutic sense of the word -- that is, unique individuals
> seeking to enhance their development in whatever direction
> it may realistically move -- but primarily pupils, relief
> recipients, and the like."

What a tender and revealing ode to the good old days when the analyst could feel socially comfortable in treating a few high income patients a year and, as Karl Menninger has pointed out, teaching them to co-exist with their symptoms at a bargain price of $10,000 to $15,000 over a period of five years or more. I have no doubt that many analysts are uneasy with this new breed of patients who grapple for survival, but do not exhibit the exotic symptomatology of "unique" individuals. But I am somewhat surprised at the extreme petulance of Dr. Brody's conclusion later in the same essay that: "Under the best of conditions, psychotherapy is a delicate flower; its survival with these burdens can be in name only."

So be it. Let a hundred flowers bloom in the greenhouse of analysis, but the mental health center moves out and works in the concrete pastures of our cities and in the mud and clay of our rural areas. This is the garden it tends.

The centers also get it from both sides on the question of the medical model --
either they are following it too slavishly, or they have abandoned it completely.

From one side of the fence Dr. Chaim Shatan warns, in a recent issue of the
INTERNATIONAL JOURNAL OF PSYCHIATRY, that if we don't take care, by 1984
Big Brother may be a community psychiatrist. Many of us are not frightened by such
a threat -- if he is a good community psychiatrist who has become involved with the
troubles and aspirations of the people, he is infinitely preferable to some technocrat
or to some mindless computocrat. Secondly, in the hardly likely event that the
community psychiatrist does evolve into Big Brother, who will be responsible but
ourselves -- we who live in the turbulent arena but hide behind comfortable jurisdictional
walls and block out the sufferings of others. From the other side of the fence the centers
are accused of excessive dilution, and even castration, of the medical model; they
are using too many non-professionals, and also training school teachers, welfare workers,
policemen, and others to work with people at a level far beyond their competence. The
good Dr. Brody asks:

> "Will a resident really be able to unburden himself, his
> resentments, his fears, his hopes, to a police officer; if he
> could, could the policeman take it?"

I don't know what kind of protective sound-proofing Dr. Brody has in his office
in New York City, but in several areas of that great metropolis I have observed police-
men making house calls in response to a suicide threat or some other psychiatric
emergency. I can assure him that the unburdening is very easy; the policeman has
been trained "to take it", and to handle such threatening situations as well or better
than most psychiatrists would under similar circumstances.

The centers are also accused, without any corresponding documentation, of handling the manageable neurotic and avoiding the psychotic patient. This is a terribly unfair charge; I have visited 33 centers in the past two years, and I have not seen one where this alleged policy holds. In point of fact, many of the patients now coming to the centers have had one or more hospitalizations in a state institution. Furthermore, we are beginning to see s sharp drop in state hospital admissions from those areas where effective centers exist and, of equal or possibly greater significance, we are also witnessing a significant decline in the re-admission of patients discharged from state hospitals. In other words, the centers are holding them in the community through various supportive actions.

As there is considerable misunderstanding of the performance of the community mental health center on the domestic scene, I confess to some free-floating anxiety about the perception of our revolution by representatives from other countries.

Just a year ago, the official newspaper of the American Psychiatric Association -- whose President had just devoted a major address to a recitation of the pitfalls and snares of community psychiatry -- featured long excerpts from a talk by Phillippe Paumelle, Director of Community Psychiatry for the Thirteenth Paris Sector. Dr. Paumelle charged that the basic difficulty with the community mental health center movement is "that it springs from the government above rather than growing from below through a genuine concern by the community for the welfare of the mentally ill."

This may be true in France, but it is certainly not true in this country. Our national government was pushed into action as a direct result of strong citizen and

medical pressures for a viable alternative to the state hospital system. President

Kennedy's historic 1963 message was a traceable outgrowth of a six-year effort by

representatives of more than 50 national organizations. In addition, 30,000 citizens

participated in very spirited fashion -- through public hearings and other forceful

representations -- in the development of 50 state mental health center plans over a

two-year period prior to the opening of the first center in this country.

No community in this country has to build a center; the amount of federal support

is not that attractive, yet citizens and their local governments have raised more than

50 percent of the funds for these centers. In scores of counties all across our land,

genuinely concerned people have voted additional taxes upon themselves in order to

establish centers which are tangible manifestations of their own civic aspirations and

of their deep-rooted commitment to their less favored brethren.

In listing some of the major criticisms of the community mental health center

movement, I may have given you the impression that there is a vocal minority which

challenges all the philosophic underpinnings of community psychiatry. Your impression

is correct and sound.

None of this is surprising, and it is all quite tolerable. In the Hegelian dialectic,

thesis leads to antithesis. Americanizing Hegel, action leads to reaction and, frequently,

to an abreactive response in which the critic brings to the surface the thoroughly re-

pressed, deceptive nostalgias of a more comfortable age when buffalo roamed our land

and custodial warehouses took care of all the "undesirables".

There is no doubt that the center movement is a potent threat to institutional

psychiatry, to entrenched private practice, and to almost all of the major "norms" of

bygone days.

However, many critics, fearful of attacking the movement frontally, pay lip service to its ideals while ripping into its alleged excesses. In other words, your goal is magnificent, but 90 percent of what you are doing is anathema. Some of us are not fooled by the lip service routine. One who is not is Dr. Melvin Sabshin, chairman of the Department of Psychiatry at the University of Illinois College of Medicine. In a recent article in the AMERICAN JOURNAL OF PSYCHIATRY entitled, "The Anti-Community Mental Health Movement", Dr. Sabshin dissects the motives of many of our critical "friends" who are really totally opposed to the community mental health center movement, and he concludes: "Indeed, the depth of the fundamental disagreement is more substantive than much of the opposition's rhetoric would indicate."

In sum, I have tried to give you an honest picture of the community mental health center movement in America at this very early stage in its development. If the report leans a bit too heavily upon the agony rather than the ecstasy, it is done thusly because there are major issues which must still be resolved. A decade or so from now maybe some of us can come back and give you a more balanced view of community psychiatry, somewhat similar to the following summary of the successes and failures of the National Health Service in Great Britain which Dr. David H. Clark gave to the American Psychiatric Association last year:

> "The National Health Service was a wonderful vision in
> 1948, born of the excitements of mighty victory, a belief that
> proper national organization could solve the problems of peace
> as well as it had those of war, and a determination to solve the
> manifest problems of the 1930s -- parents too poor to pay for
> necessary treatment for their children, hospitals shabby, dis-
> organized, and forever in debt, doctors flocking to wealthy

middle-class areas and neglecting the sick poor of the in-
dustrial cities. It was based on a great ideal -- that no
individual or family should have to bear unaided the cost of
illness. Like all revolutionary schemes for solving human
ills, it has had both successes and failures. In general, it has
solved the problems it set out to remedy, but created others which
it cannot cure. "

In like manner, community psychiatry is a great ideal which is being tested daily

in the crucible of experience. For those of us who have had the privilege of tilting a lance

or two against man's inhumanity to the mentally ill, the future of the community mental

health center is bright and clear, for our effort is directed toward bringing mental health

services to all segments of our society in a troubled age when the individual is increasingly

lost in the impersonalities of mass technologicy and dehumanized services.

Our credo is akin to that of the distinguished American novelist William Faulkner

who, on receiving the Nobel Prize in 1950, proclaimed:

"I believe that man will not merely endure;

he will prevail. "